Saddleback Portable X-ray

Phone: 714.835.2915
Fax: 714.543.3114

Radiology
ORDER REPORT

PATIENT NAME:	**PATIENT ID#:**	**DATE OF BIRTH:**	**SEX:**	
ADDRESS:	**CITY, STATE & ZIP: ,**		**PHONE#:**	
ORDERING FACILITY:	**ADDRESS:**			
CITY, STATE & ZIP:	**PHONE#:**	**FAX#:**	**NPI#:**	
REQUESTED DATE/TIME OF SERVICE:		**TECHNOLOGIST:**		
REFFERING DR'S NAME:	**NPI#:**	**PHONE#:**	**FAX#:**	

CPT CODE #1:	**PROCEDURE #1:**	
CPT CODE #2:	**PROCEDURE #2:**	

SYMPTOMS:

MEDICARE#:	**MEDICAID#:**	**INSURANCE CO.:**	**POLICY/GROUP: /**

PHYSICIAN'S SIGNATURE: _____ **Date:** ____/____/____